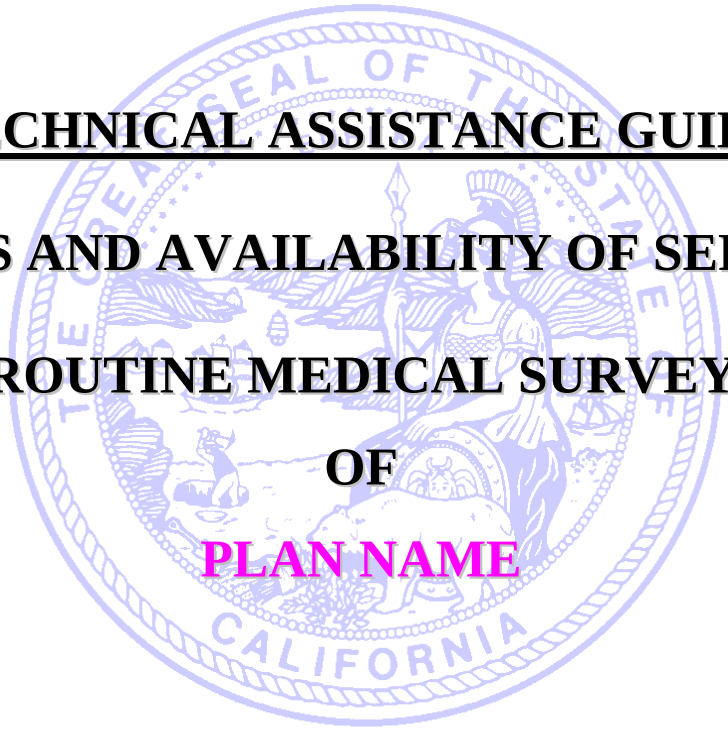
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS



TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

PLAN COPY

Issuance of this October 1, 2008 Technical Assistance Guide renders all other versions obsolete.

FULL SERVICE TAG

TABLE OF CONTENTS

Access and Availability of Services Requirements

Requirement AA-001:	**Number and Distribution of Primary Care Providers**	**Page 2**
Requirement AA-002:	**Number and Distribution of Specialists**	**Page 4**
Requirement AA-003:	**Number and Distribution of Hospitals and Ancillary Care**	**Page 7**
Requirement AA-004:	**Hours of Operation and After Hours Service**	**Page 10**
Requirement AA-005:	**Appointment Availability**	**Page 12**
Requirement AA-006:	**Enrollee Health Education**	**Page 14**
Requirement AA-007:	**Preventive Health Care (formerly QM-005)**	**Page 15**
Requirement AA-008:	**Mental Health Parity Communication of Benefit Information**	**Page 17**
Requirement AA-009:	**List of Contracting Providers Available Upon Request**	**Page 21**

FULL SERVICE TAG

Requirement AA-001: Number and Distribution of Primary Care Providers

Statutory/Regulatory Citations:

28 CCR 1300.51 (d) H (i)
Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees

28 CCR 1300.67.2 (a) and (d)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

28 CCR 1300.67.2.1 (a)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

CA Health and Safety Code section 1367 (e) (1)
All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with section 1367.03.

Section 1367.03 (Note the Access and Availability Section of the TAG is subject to change based on new regulation development pursuant to section 1367.03.)

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Contracting/Provider Relations
- QM Director

Documents to be Reviewed:

- Policies and procedures that define the standards for the number and distribution of primary care providers within the service area
- Policies and procedures to periodically update/review the standards for the number and distribution of primary care providers within the service area
- Distribution service area maps indicating location and numbers of enrollees in comparison with primary care providers

FULL SERVICE TAG

- Plan primary health care access reports that provide information on provider distributions, closed practices and the like.
- Record of periodic review of the standards for the number and distribution of primary care providers within the service area, including minutes of relevant Committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents describing how the Plan monitors and ensures compliance with network standards.
- Corrective action plans for areas where access does not meet the standards
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The Plan has established a standard for geographic distribution of primary care providers (PCPs). The standard provides for each enrollee to have a residence or workplace within 30 minutes or 15 miles of at least one PCP or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate distribution of PCPs. 28 CCR 1300.51 (d) H (i); 28 CCR 1300.67.2.1 (a)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on geographic distribution of primary care providers?			
1.2 Does the Plan's standard provide for each enrollee to have a residence or workplace within 30 minutes or 15 miles of at least one PCP?			
1.3 If "no," has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 2:

2. The Plan has established a standard for the ratio of PCPs to enrollees within the service area. The standard provides for at least one full-time equivalent PCP for each 2,000 enrollees or the Plan may provide an alternative mechanism. (i.e., via the filing of a material modification) to demonstrate an adequate ratio of PCPs to enrollees. 28 CCR 1300.67.2 (a) and (d)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard on the ratio of PCPs to enrollees?			
2.2 Does the Plan's standard provide for at least one PCP for each 2,000 enrollees?			
2.3 If "no," has the Plan established an alternative standard?			
2.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 3:

3. The Plan has established a mechanism that ensures that primary health care services are reasonably accessible to all enrollees. CA Health & Safety Code section 1367 (e) (1)

Assessment Question	Yes	No	N/A
3.1 Does the Plan have mechanisms to ensure reasonable access to health care services for all enrollees?			

End of Requirement AA-001: Number and Distribution of Primary Care Providers

FULL SERVICE TAG

Requirement AA-002: Number and Distribution of Specialists

Statutory/Regulatory Citations:

28 CCR 1300.67.2 (b-f)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(b) Hours of operation and provision for after-hour services shall be reasonable;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments; …

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

28 CCR 1300.67.2.1 (a)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.74.72 (a), (b) and (f)
(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.
(b) A plan shall provide coverage for the diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:
(1) acting within the scope of their licensure, and
(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

FULL SERVICE TAG

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

CA Health and Safety Code section 1345 (i)
(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

CA Health and Safety Code section 1367 (e) (1)
All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Contracting/Provider Relations
- QM Director

Documents to be Reviewed:

- Policies and procedures that define the standards for the number and distribution of specialists
- Policies and procedures to periodically review and update the standards for the number and distribution of specialists
- Record of periodic review of the standards for the number and distribution of specialists, including minutes of relevant Committee Meetings (QM Committee, Public Policy Committee, etc.)
- Documents that demonstrate how the Plan ensures that appropriate specialty services are available without delays detrimental to the health of the enrollees
- Documents that demonstrate how the Plan defines high-volume specialists
- Documents that define the availability of specialty services (including the number or percentage of open practices)
- Summary referral data indicating number of referrals for each specialty within a given timeframe
- Plan specialist access reports and analysis
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The Plan has established a standard for the number of physicians within the service area. The standard provides for at least one full-time equivalent physician to each 1,200 enrollees or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate ratio of physicians to enrollees. 28 CCR 1300.67.2 (d) and (e)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the ratio of physicians to enrollees?			
1.2 Does the Plan's standard provide for at least one physician for each 1,200 enrollees?			
1.3 If "no," has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 2:

2. The Plan has established a standard for the distribution of and accessibility to medically required specialists. 28 CCR 1300.67.2 (d) and (e)

FULL SERVICE TAG

Assessment Question	Yes	No	N/A
2.1 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network?			

Key Element 3:

3. The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. 28 CCR 1300.74.72 (a) (b) (f) and (g); 28 CCR 1300.67.2(b-f); 28 CCR 1300.67.2.1 (a); CA Health & Safety Code section 1345 (i) and section 1367 (e) (1)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have an established standard for the number and geographic distribution of mental health providers who can treat severe mental illness of a person of any age and serious emotional disturbances of a child?			
3.2 Do the standards take into account the various types of mental health practitioners (psychiatrist, psychologist, MFCC, LCSW) acting within the scope of their licensure?			
3.3 Do the standards take into account the various specialties and sub-specialties required to treat the population?			
3.4 Does the Plan measure the adequacy of its network against its standards at least annually?			
3.5 Does the Plan take appropriate action based on adequacy findings?			
3.6 Has the Plan implemented a process to verify periodically that participating mental health providers are accepting new patients?			
3.7 Does the Plan take the periodic verification information into account when monitoring the adequacy of its network?			

End of Requirement AA-002: Number and Distribution of Specialists

FULL SERVICE TAG

Requirement AA-003: Number and Distribution of Hospitals and Ancillary Care

Statutory/Regulatory Citations:

28 CCR 1300.51 (d) (H) (ii) and (iv)
(d) Exhibits to Plan Application.
H. Geographical Area Served.
Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan, which does not meet these guidelines, does not meet the requirement of reasonable accessibility.
(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.
(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

28 CCR 1300.67.2 (c)
(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

28 CCR 1300.67.2.1 (a)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.74.72 (a)
(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

FULL SERVICE TAG

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Contracting/Provider Relations
- QM Director

Documents to be Reviewed:

- Policies and procedures that define the standards for the number and geographic distribution of hospitals within the service area
- Policies and procedures that define the standards for the number and geographic distribution of emergency services within the service area
- Policies and procedures that define the standards for the number and geographic distribution of ancillary care facilities within the service area
- Policies and procedures that define the standards for the number and geographic distribution of mental health facilities and providers
- Plan hospital, emergency, ancillary care facility and mental health provider and facility access and/or geographic reports and associated analysis (within each service area and by county, if applicable)
- Record of periodic review of the standards for the number and geographic distribution of hospitals, emergency services, and ancillary service facilities within the service area, including minutes of relevant Committee Meetings (QM Committee, Public Policy Committee, etc.)
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).

Key Element 1:

1. The Plan has established a standard for the geographic distribution of hospitals. The standard provides for each enrollee to have a residence or workplace within 30 minutes or 15 miles of a contracting or Plan-operated hospital or the Plan may have an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate distribution of hospitals. 28 CCR 1300.51 (d) H (ii)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the geographic distribution of hospitals in its network?			
1.2 Does the Plan's standard provide for each enrollee to have a residence or workplace within 30 minutes or 15 miles of a contracting or Plan-operated hospital?			
1.3 If "no," has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 2:

2. The Plan has established a mechanism that ensures that the contracting hospital(s) in its service areas has/have the capacity to serve the entire dependent enrollee population based upon normal utilization. 28 CCR 1300.51 (d) H (ii)

Assessment Question	Yes	No	N/A
2.1 Has the Plan established a mechanism that ensures that the contracting hospital(s) in its service areas has/have the capacity to serve the entire dependent enrollee population based upon normal utilization?			

FULL SERVICE TAG

Key Element 3:

3. The Plan has established a standard for the geographic distribution of emergency health care services. The standard provides for each enrollee to have a residence or workplace within 30 minutes or 15 miles of a contracting or Plan-operated emergency health care facility or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate distribution of emergency health care services. 28 CCR 1300.51 (d) H (ii)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have an established standard on the geographic distribution of emergency health care services in its network?			
3.2 Does the Plan's standard provide for each enrollee to have a residence or workplace within 30 minutes or 15 miles of a contracting or Plan-operated emergency health care facility?			
3.3 If "no," has the Plan established an alternative standard?			
3.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 4:

4. The Plan has established a standard for the geographic distribution of ancillary services, including laboratory and pharmacy services. The standard provides for distribution of these services within a reasonable distance relative to PCPs or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate distribution of ancillary services to enrollees. 28 CCR 1300.51 (d) H (iv)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have an established standard on the geographic distribution of ancillary services in its network?			
4.2 Does the Plan's standard provide for distribution of these services within a reasonable distance relative to PCPs?			
4.3 If "no," has the Plan established an alternative standard?			
4.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

Key Element 5:

5. The Plan ensures that its network of mental health providers and facilities is adequate to meet the mental health needs of its enrollees. 28 CCR 1300.74.72(a)

Assessment Questions	Yes	No	N/A
5.1 Does the Plan have an established standard for the number and geographic distribution of mental health facilities that can treat severe mental illness of a person of any age and serious emotional disturbances of a child?			
5.2 Does the Plan measure the adequacy of its network against its standards at least annually?			

End of Requirement AA-003: Number and Distribution of Hospitals and Ancillary Care

FULL SERVICE TAG

Requirement AA-004: Hours of Operation and After Hours Service

Statutory/Regulatory Citations:

28 CCR 1300.67.2 (b), (d) and (f)
(b) Hours of operation and provision for after-hour services shall be reasonable;
(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.74.72 (f)
(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

28 CCR 1300.80 (b) (5) (D)
(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.
(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:
(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- QM Director
- Provider Relations Manager

Documents to be Reviewed:

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care;
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan's telephone system or other methodologies (such as random calling at various times and dates)
- Committee Meeting minutes (of any/all appropriate committees)
- Provider Manual or other methods to communicate standards to providers
- Corrective Action Plans
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

FULL SERVICE TAG

Key Element 1:

1. The Plan has established a standard defining reasonable hours of operation for provider health care facilities that are sufficient to prevent delays detrimental to the health of enrollees. 28 CCR 1300.67.2 (b) and (d); 28 CCR 1300.74.72 (f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?			
1.2 Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of enrollees?			

Key Element 2:

2. The Plan has established standards that ensure that the availability of and access to after-hours services both at the Plan and provider-level are sufficient to prevent delays detrimental to the health of enrollees. 28 CCR 1300.67.2 (b) and (d)

Assessment Questions	Yes	No	N/A
Does the Plan have established standards on availability of and access to after-hours services which address: 2.1 provider message/answering service requirements?			
2.2 availability of providers?			
2.3 provider response to messages left after hours?			
2.4 Plan services (e.g., customer service)?			
2.5 Do the standards ensure that availability of an access to after-hours services is sufficient to prevent delays detrimental to the health of enrollees?			

Key Element 3:

3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services. 28 CCR 1300.67.2 (d); 28 CCR 1300.80 (b) (5) (D)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan disseminate its standard to providers (e.g., via facility contracts, provider manual, etc.)?			
3.2 Does the Plan regularly measure providers' performance against its standard?			
3.3 Does the Plan implement corrective action and follow-up review to address any deficiencies?			
3.4 Does the Plan periodically review the appropriateness of its standard and update it when indicated?			

End of Requirement AA-004: Hours of Operation and After Hours Service

FULL SERVICE TAG

Requirement AA-005: Appointment Availability

Statutory/Regulatory Citations:

28 CCR 1300.67.2 (f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.70 (b) (2) (G) (5)
Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

28 CCR 1300.74.72 (b) and (f)
(b) A health plan shall provide coverage for the diagnosis, and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:
(1) acting within the scope of their licensure, and
(2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.
(f) A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.72…

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- QM Director
- Director of Provider Relations
- Director of Network Management or its equivalent

Documents to be Reviewed:

- Policies and procedures that define appointment availability
- Appointment availability studies
- Provider waiting time studies
- Enrollee and provider satisfaction surveys
- Reports on complaint and grievances
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates)
- Committee or applicable subcommittee minutes, prior two years
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.

Key Element 1:

1. Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. 28 CCR 1300.67.2 (f); 28 CCR 1300.74.72 (b) and (f)

FULL SERVICE TAG

Assessment Questions	Yes	No	N/A
1.1 Does the health plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments?			
Does the documented system for monitoring and evaluating access to care include? 1.2 Initial consultation appointments?			
1.3 Urgent appointments?			
1.4 On-going care appointments?			
1.5 In-office waiting times?			
1.6 Does the Plan have separate standards for mental health appointment availability for adults, adolescents, and children by type of appointment and type of provider?			
1.7 Does the plan monitor performance against the standards?			
1.8 Does the plan monitor telephone service accessibility?			
1.9 Does the plan evaluate network capacity? (This is the percentage of the network accepting referrals / new patients.)			
1.10 Does the Plan ensure that there are open practices that are accepting new patients?			
1.11 Does the plan have a procedure for providing a list of available mental health providers to enrollees (near their home or office)?			
1.12 Does the plan monitor in-office waiting time?			
When the plan identifies problems, does it: 1.12 Take action to ensure appointment availability?			
1.13 Monitor to assure improvements are maintained?			

End of Requirement AA-005: Appointment Availability

FULL SERVICE TAG

Requirement AA-006: Enrollee Health Education

Statutory/Regulatory Citations:

28 CCR 1300.67.2 (g)
A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Supervisor or Manager of Health Education or equivalent
- QM Director
- Director or Manager of Customer Relations or Member Services

Documents to be Reviewed:

- Policies and procedures of the health education program
- Health education program description
- Plan and delegate Web sites
- Patient education materials regarding the accessibility of service (e.g., certificate of coverage member handbook);
- Plan reviews of delegated entities' health education programs and notification to enrollees of how to access services; and

Key Element 1:

1. The Plan regularly distributes materials to each enrollee that explain how to obtain services. 28 CCR 1300.67.2 (g)

Assessment Questions	Yes	No	N/A
Has the Plan developed materials that explain how to obtain: 1.1 primary care services?			
1.2 specialty care services?			
1.3 after-hours care?			
1.4 urgent care?			
1.5 emergency care?			
1.6 Does the Plan regularly distribute the materials to enrollees?			

Key Element 2:

2. The Plan ensures that delegated entities inform enrollees how to access services. 28 CCR 1300.67.2 (g)

Assessment Questions	Yes	No	N/A
Does the Plan ensure that delegated entities inform enrollees how to obtain (as applicable to the delegate's responsibilities): 2.1 primary care services?			
2.2 specialty care services?			
2.3 after-hours care?			
2.4 urgent care?			
2.5 emergency care?			

End of Requirement AA-006: Enrollee Health Education

FULL SERVICE TAG

Requirement AA-007: Preventive Health Care (formerly QM-005)

Statutory/Regulatory Citations:

28 CCR 1300.67 (f)
Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
(1) Reasonable health appraisal examinations on a periodic basis;
(2) A variety of voluntary family planning services;
(3) Prenatal care;
(4) Vision and hearing testing for persons through age 16;
(5) Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;
(6) Venereal disease tests;
(7) Cytology examinations on a reasonable periodic basis;
(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.70 (b) (2) (G) (5) and (6) *(Applicable to delegated groups only)*
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- QA Coordinator

Documents to be Reviewed:

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- HEDIS results for the last three years, if applicable
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

FULL SERVICE TAG

Key Element 1:

1. The Plan has established preventive care guidelines. The Plan has disseminated its guidelines to its providers, regularly monitors performance against the standards and addresses any deficiencies. 28 CCR 1300.67 (f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established preventive guidelines?			
1.2 Does the Plan use appropriate methods in developing or adopting preventive guidelines?			
1.3 Are the guidelines comprehensive?			
1.4 Does the Plan have an effective mechanism for distributing its guidelines to participating providers?			
1.5 Does the Plan monitor the provision of preventive services on an individual and plan-wide basis?			
1.6 Does the Plan regularly measure the level of preventive care provided to enrollees against its established guidelines?			
1.7 Does the Plan critically evaluate the results of preventive care monitoring?			
1.8 Does the Plan develop and implement corrective actions or QM programs with measurable goals to increase levels of preventive care for enrollees?			
1.9 Does the Plan re-measure and critically evaluate the results of corrective actions or QM programs to increase levels of preventive care for enrollees?			
1.10 Does the Plan develop and implement additional corrective actions or QM programs based on the critical evaluation of its past corrective actions or QM programs?			

Key Element 2:

2. The Plan has an effective health education program designed to educate enrollees regarding personal health behavior and health care, including recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan. 28 CCR 1300.67 (f) (8)

Assessment Question	Yes	No	N/A
2.1 Does the Plan have effective preventive health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan?			

End of Requirement AA-007: Preventive Health Care

FULL SERVICE TAG

Requirement AA-008: Mental Health Parity Communication of Benefit Information

Statutory/Regulatory Citations:

28 CCR 1300.63.2 (c) (14)
(c) The combined evidence of coverage and disclosure form shall contain at a minimum the following information:
(14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

28 CCR 1300.67.2 (g)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

28 CCR 1300.74.72 (a), (e), (f), (g) and (i)
(a) The mental health services required for the diagnosis and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

(e) "Pervasive Developmental Disorders shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders—IV—Text Revision (July 2000)

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:
(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services.
(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage.

(i) A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

CA Health and Safety Code section 1374.72 (a-e)
(a) Every health plan contract issued, amended, renewed on or after July 1, 2000, that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:
(1) Outpatient services.
(2) Inpatient hospital services.
(3) Partial hospital services.
(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

FULL SERVICE TAG

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Copayments.
(3) Individual and family deductibles.

(d) For the purposes of this section, “severe mental illnesses” shall include:
(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism
(8) Anorexia nervosa
(9) Bulimia nervosa

(e) For purposes of this section a child suffering from “serious emotional disturbances of a child” shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Welfare and Institutions Code 5600.3 (a) (2)
(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:
(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
(i) The child is at risk of removal from home or has already been removed from the home.
(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Director of Customer Service
- QA Director
- Compliance Officer

Documents to be Reviewed:

- Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form (for each applicable product line)
- Schedule of Benefits (for each applicable product line)
- Marketing materials, such as summaries of benefits, and presentation materials, such as PowerPoint presentations
- Enrollee education materials from the Plan and, if applicable, the Delegate. These may include brochures on mental health services and enrollee newsletters that contain articles on mental health benefits and services.
- Sample enrollee identification card for each applicable product line
- Customer Service staff reference materials (desktop procedures, scripts, training materials, etc.)
- Plan’s website section that communicates mental health benefits and access information.

FULL SERVICE TAG

Key Element 1:

1. The Plan's Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form and the Schedule of Benefits accurately and clearly describe benefit coverage for mental health parity diagnoses/conditions, distinguish between parity and non-parity mental health benefits, if applicable, and describe how enrollees can obtain both parity and non-parity mental health benefits. 28 CCR 1300.63.2 (c) (14); 28 CCR 1300.74.72 (a) and (i)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan's EOC accurately and clearly describe benefit and coverage information for mental health parity conditions?			
1.2 Does the Plan's EOC distinguish between parity and non-parity mental health benefits?			
1.3 Does the EOC describe how enrollees can obtain both parity and non-parity mental health benefits?			

Key Element 2:

2. The Plan's marketing materials and enrollee educational materials accurate present benefit and coverage information for parity diagnoses/conditions and clearly distinguish between parity and non-parity mental health benefits, if applicable. 28 CCR 1300.67.2 (g); 28CCR 1300.74.72 (a) and (i)

Assessment Questions	Yes	No	N/A
2.1 Do the plan's marketing and enrollee education materials accurate present benefit and coverage information for parity diagnoses/conditions?			
2.2 Do the plan's marketing and enrollee education materials clearly distinguish between parity and non-parity mental health benefits, if applicable?			

Key Element 3:

3. The Plan regularly distributes materials to each enrollee that explains how to obtain services. 28 CCR 1300.67.2 (g); 28 CCR 1300.74.72 (a)

Assessment Questions	Yes	No	N/A
Has the Plan developed materials that explain how to obtain: 3.1 Routine mental health services?			
3.2 After-hours mental health services?			
3.3 Urgent mental health services?			
3.4 Emergency mental health services?			
3.5 Do the plan's marketing and enrollee education materials inform enrollees how to obtain covered services in accordance with the specific needs of the enrollee (i.e. based on diagnosis of autism, depression, eating disorders, etc.)?			
3.6 Does the Plan regularly distribute the materials to enrollees?			

Key Element 4:

4. If a Plan contracts with a specialized health care plan to provide mental health services, the specialized plan maintains a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits, providers, coverage, and any other relevant information. 28 CCR 1300.74.72 (f) and (g) (1)

Assessment Question	Yes	No	N/A
4.1 Does the specialized plan maintain a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits, providers and coverage?			

FULL SERVICE TAG

Key Element 5:

5. If the Plan contracts with a specialized health care service plan to provide mental health services, the plan includes on the enrollee's ID card the telephone number that enrollees can call during business hours to obtain information regarding benefits, providers, coverage, and any other relevant information. 28 CCR 1300.74.72 (f) and (g) (2)

Assessment Question	Yes	No	N/A
5.1 Does the Plan include – on the enrollee's ID card – the specialized plan's telephone number that enrollees can call during business hours to obtain information regarding benefits, providers and coverage?			

Key Element 6:

6. The Plan's Member/Customer Service staff accurately present mental health benefit and coverage information and how to obtain mental health services for parity and non-parity conditions. 28 CCR 1300.74.72 (f) and (g) (1)

Assessment Questions	Yes	No	N/A
6.1 Do Member/Customer Service staff have the information necessary to accurately assist enrollees in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee's mental health services?			
6.2 Are the scripts, system documentation, training materials and other materials used by Member Services about mental health coverage accurate?			
6.3 Do audit and monitoring reports validate that accurate information regarding mental health parity benefits is monitored and communicated?			

End of Requirement AA-008: Mental Health Parity Communication of Benefit Information

FULL SERVICE TAG

Requirement AA-009: List of Contracting Providers Available Upon Request

Statutory/Regulatory Citations:

CA Health & Safety Code section 1367.26

(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

(1) Primary care providers.
(2) Medical groups.
(3) Independent practice associations.
(4) Hospitals.
(5) All other available contracting physicians, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.

(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications and any recognized subspeciality qualifications a specialist may have.

(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Contracting / Provider Relations
- Director of QM

Documents to be Reviewed:

- Plan Provider Directory
- Electronic version of the Plan’s Provider Directory and the Plan’s online provider directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider’s contact information.

FULL SERVICE TAG

Key Element 1:

1. The Plan has a complete list of contracted providers that includes all required information. CA Health & Safety Code section 1367.26

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a list of all of its contracted providers, including primary care providers, medical groups, independent practice associations, hospitals, and all other health professionals, including psychologists, licensed clinical social workers, marriage and family therapists, and nurse midwives?			
1.2 Does the Plan maintain records of each provider's professional degree, board certifications, and any recognized subspecialty qualifications that a specialist may have?			
Does the Plan's list of contracted providers:			
1.3 Indicate which providers have notified the plan that they have closed practices?			
1.4 Indicate which providers are not accepting new patients at this time?			
1.5 Indicate that the list is subject to change without notice?			
1.6 Include a telephone number that enrollees can contact to obtain information regarding a particular provider, including whether or not that provider is accepting new patients?			

Key Element 2:

2. The Plan properly updates its list of contracted providers. CA Health & Safety Code section 1367.26

Assessment Questions	Yes	No	N/A
2.1 Does the Plan either: a) provide the provider list in written form to its enrollees and prospective enrollees upon request or, b) with the permission of the enrollee or prospective enrollee, refer the inquiry to the Plan's website?			
2.2 Does the Plan have policies and procedures that ensure that all of the information contained in its provider directory is updated quarterly?			

Key Element 3:

3. The Plan provides provider information to its enrollees upon telephone or written request. CA Health & Safety Code section 1367.26

Assessment Questions	Yes	No	N/A
3.1 Does the Plan provide enrollees and prospective enrollees with provider information through their toll-free telephone number or in writing?			
3.2 Does the Plan provide information to enrollees and prospective enrollees about each provider's professional degree, board certifications, and any recognized sub-specialty qualifications that a sub-specialist may have?			

End of Requirement AA-009: List of Contracting Providers Available Upon Request